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AMENDED IN ASSEMBLY MAY 22, 1998
AMENDED IN ASSEMBLY APRIL 27, 1998
AMENDED IN ASSEMBLY FEBRUARY 24, 1998

CALIFORNIA LEGISLATURE—1997–98 REGULAR SESSION

ASSEMBLY BILL

No. 1667

**Introduced by Assembly Members Migden, Baugh, and
Richter**

January 14, 1998

~~An act to amend Section 1368 of, and to add Article 12 (commencing with Section 1399.80) to Chapter 2.2 of Division 2 of, the Health and Safety Code, and to add Article 2.7 (commencing with Section 10309) to Chapter 4 of Part 2 of Division 2 of the Insurance Code, relating to health. An act to amend Sections 1368, 1368.01, 1368.03, and 1368.04 of, and to add Article 12 (commencing with Section 1399.80) to Chapter 2.2 of Division 2 of, the Health and Safety Code, and to add Article 2.55 (commencing with Section 10145.80) to Chapter 1 of Part 2 of Division 2 of the Insurance Code, relating to health insurance.~~

LEGISLATIVE COUNSEL'S DIGEST

AB 1667, as amended, Migden. Health care service plans: disability insurers: appeals.

(1) Under existing law, the Knox-Keene Health Care Service Plan Act of 1975, health care service plans are regulated by the Department of Corporations.

Existing law requires every health care service plan to establish and maintain a grievance system approved by the department under which enrollees and subscribers may submit their grievances to the plan. Under existing law, after participating for at least 60 days in, or completing, the plan's grievance process, an enrollee or subscriber may submit the grievance or complaint to the department for review.

This bill would require health care service plans to provide subscribers and enrollees with written responses to grievances, as specified, and would provide that a grievance may be submitted to the department by an enrollee or subscriber after participating in the plan's grievance process for 45 days. The bill would require the department to respond to each grievance in writing within 45 days.

(2) Existing law requires every health care service plan and disability insurer to establish a reasonable external, independent review process to examine coverage decisions regarding experimental or investigational therapies for individual enrollees or insureds who have a terminal condition and meet certain specified criteria.

This bill would, on and after January 1, 2000, require the Commissioner of Corporations and the Insurance Commissioner to contract with one or more independent review organizations to conduct independent medical reviews, as specified. The bill would require the Commissioner of Corporations and the Insurance Commissioner to contract, by July 1, 1999, with a private, nonprofit accrediting organization to accredit the independent medical review entities that are to conduct these independent reviews. The bill would enact other related provisions.

(3) Under existing law, a willful violation of the provisions governing health care service plans is a crime.

By changing the definition of the crime applicable to these plans, this bill would impose a state-mandated local program.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs

mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

(5) This bill would also provide that it shall not become operative unless SB 1504 and SB 1653 are also enacted and become operative.

~~Under existing law, the Knox-Keene Health Care Service Plan Act of 1975, health care service plans are regulated by the Department of Corporations. Existing law requires health care service plans to provide an external, independent review process to examine the plan's decisions regarding experimental or investigational therapies for certain enrollees.~~

~~This bill would establish in the department the Independent Health Care Appeals Program for Health Care Service Plans to provide an independent medical necessity or appropriateness of services review of final decisions of a health care service plan to deny, reduce, or terminate benefits in the event the final decision is contested by an enrollee. The bill would authorize the department to charge to the enrollee a processing fee to apply for review under the program. The bill would require the Commissioner of Corporations to, among other things, contract with one or more independent utilization review organizations in the state to conduct the appeal reviews and make a recommendation. The bill would require the plan to implement the recommendation. The bill would require the plan to bear the cost of the appeal review pursuant to a schedule of fees established by the department.~~

~~Existing law requires every health care service plan to establish and maintain a grievance system approved by the department under which enrollees and subscribers may submit their grievances to the plan. Under existing law, after participating for at least 60 days in, or completing, the plan's grievance process, an enrollee or subscriber may submit the grievance or complaint to the department for review. Under existing law, the plan's grievance system is required to include a system for complaints that are pending and unresolved for 30 days or more.~~

~~This bill would authorize an enrollee or subscriber to submit the grievance or complaint to the Independent Health Care Appeals Program for Health Care Service Plans proposed by this bill, rather than the department. The bill would also require that the enrollee participate in the plan's grievance process for at least 30 days, rather than for at least 60 days, or for 72 hours, under specified circumstances.~~

~~Existing law provides for the regulation of policies of disability insurance administered by the Insurance Commissioner.~~

~~This bill would establish in the Department of Insurance the Independent Health Care Appeals Program for Disability Insurers to provide an independent medical necessity or appropriateness of services review of final decisions of disability insurers to deny, reduce, or terminate benefits in the event the final decision is contested by a policyholder identical to that described above for health care service plans, but under the direction of the Insurance Commissioner.~~

~~Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~no~~ yes.~~

The people of the State of California do enact as follows:

1 ~~SECTION 1. Section 1368 of the Health and Safety~~

2 ~~SECTION 1. This act shall be known as the Patient's~~
3 ~~Independent Medical Review Act of 1998.~~

4 ~~SEC. 2. Section 1368 of the Health and Safety Code is~~
5 ~~amended to read:~~

6 ~~1368. (a) Every plan shall do all of the following:~~

7 ~~(1) Establish and maintain a grievance system~~
8 ~~approved by the department under which enrollees may~~
9 ~~submit their grievances to the plan. Each system shall~~
10 ~~provide reasonable procedures in accordance with~~
11 ~~department regulations that shall ensure adequate~~
12 ~~consideration of enrollee grievances and rectification~~
13 ~~when appropriate.~~

14 ~~(2) Inform its subscribers and enrollees upon~~
15 ~~enrollment in the plan and annually thereafter of the~~
16 ~~procedure for processing and resolving grievances. The~~

1 information shall include the location and telephone
2 number where grievances may be submitted.

3 (3) Provide forms for ~~complaints~~ *grievances* to be
4 given to subscribers and enrollees who wish to register
5 written ~~complaints~~ *grievances*. The forms used by plans
6 licensed pursuant to Section 1353 shall be approved by
7 the commissioner in advance as to format.

8 (4) *Provide subscribers and enrollees with written*
9 *responses to grievances, with a clear and concise*
10 *explanation of the reasons for the plan's response. For*
11 *grievances involving the denial, significant delay,*
12 *termination, or other limits on health care services, the*
13 *plan response shall describe the criteria used and the*
14 *clinical reasons for its decision, including all criteria and*
15 *clinical reasons related to medical necessity or medical*
16 *appropriateness.*

17 (5) Keep in its files all copies of ~~complaints~~ *grievances*,
18 and the responses thereto, for a period of five years.

19 (b) (1) (A) After either completing the grievance
20 process described in subdivision (a), or participating in
21 the process for at least ~~60~~ 45 days, a subscriber or enrollee
22 may submit the grievance ~~or—complaint~~ to the
23 department for review. In any case determined by the
24 department to be a case involving an imminent and
25 serious threat to the health of the patient, including, but
26 not limited to, the potential loss of life, limb, or major
27 bodily function, or in any other case where the
28 department determines that an earlier review is
29 warranted, a subscriber or enrollee shall not be required
30 to complete the grievance process or participate in the
31 process for at least ~~60~~ 45 days.

32 (B) A grievance ~~or—complaint~~ may be submitted to the
33 department for review and resolution prior to any
34 arbitration.

35 (C) Notwithstanding subparagraphs (A) and (B), the
36 department may refer any grievance ~~or—complaint~~ to the
37 State Department of Health Services, the Department of
38 Aging, the federal Health Care Financing
39 Administration, or any other appropriate governmental
40 entity for investigation and resolution.

1 (2) If the subscriber or enrollee is a minor, or is
2 incompetent or incapacitated, the parent, guardian,
3 conservator, relative, or other designee of the subscriber
4 or enrollee, as appropriate, may submit the grievance ~~or~~
5 ~~complaint~~ to the department as the agent of the
6 subscriber or enrollee. Further, a provider may join with,
7 or otherwise assist, a subscriber or enrollee, or the agent,
8 to submit the grievance ~~or complaint~~ to the department.
9 In addition, following submission of the grievance ~~or~~
10 ~~complaint~~ to the department, the subscriber or enrollee,
11 or the agent, may authorize the provider to assist,
12 including advocating on behalf of the subscriber or
13 enrollee. For purposes of this section, a “relative”
14 includes the parent, stepparent, spouse, adult son or
15 daughter, grandparent, brother, sister, uncle, or aunt of
16 the subscriber or enrollee.

17 (3) Every health care service plan regulated by the
18 department shall prominently display in every plan
19 contract, on enrollee and subscriber evidence of
20 coverage forms, on the complaint forms required under
21 paragraph (3) of subdivision (a), and on all written
22 responses to grievances ~~and complaints~~, a notice of the
23 right to submit unresolved grievances ~~and complaints~~ to
24 the department for review.

25 (4) The department shall review the written
26 documents submitted with the subscriber’s or the
27 enrollee’s request for review, or submitted by the agent
28 on behalf of the subscriber or enrollee. The department
29 may ask for additional information, and may hold an
30 informal meeting with the involved parties, including
31 providers who have joined in submitting the grievance ~~or~~
32 ~~complaint~~, or who are otherwise assisting or advocating
33 on behalf of the subscriber or enrollee. The department
34 shall send a written notice of the final disposition of the
35 grievance ~~or complaint~~, and the reasons therefor, to the
36 subscriber or enrollee, the agent, to any provider that has
37 joined with or is otherwise assisting the subscriber or
38 enrollee, and to the plan, within ~~60~~ 45 calendar days of
39 receipt of the request for review unless the commissioner,
40 in his or her discretion, determines that additional time

1 is reasonably necessary to fully and fairly evaluate the
2 relevant grievance ~~or complaint~~. ~~Distribution~~. In any
3 decision not subject to the independent medical review
4 system established pursuant to Article 12 (commencing
5 with Section 1399.80), the department's written notice
6 shall include, at a minimum, the following:

7 (A) A summary of its findings and the reasons why the
8 department found the plan to be, or not to be, in
9 compliance with any applicable laws, regulations, or
10 orders of the commissioner.

11 (B) A discussion of the department's contact with any
12 independent qualified medical provider, or any other
13 independent expert relied on by the department, along
14 with a summary of the views of that provider or expert.

15 (C) If the enrollee's grievance is sustained in whole or
16 part, information about the corrective action taken and
17 any penalties imposed by the department.

18 Distribution of the written notice shall not be deemed
19 a waiver of any exemption or privilege under existing law,
20 including, but not limited to, Section 6254.5 of the
21 Government Code, for any information in connection
22 with and including the written notice, nor shall any
23 person employed or in any way retained by the
24 department be required to testify as to that information
25 or notice.

26 (5) On or before January 1, ~~1997~~ 1999, the
27 commissioner shall establish and maintain a system of
28 aging of ~~complaints~~ grievances that are pending and
29 unresolved for ~~60~~ 45 days or more, that shall include a
30 brief explanation of the reasons each ~~complaint~~ grievance
31 is pending and unresolved for ~~60~~ 45 days or more.

32 ~~(5)~~

33 (6) A subscriber or enrollee, or the agent acting on
34 behalf of a subscriber or enrollee, may also request
35 voluntary mediation with the plan prior to exercising the
36 right to submit a grievance ~~or complaint~~ to the
37 department. The use of mediation services shall not
38 preclude the right to submit a grievance ~~or complaint~~ to
39 the department upon completion of mediation. In order
40 to initiate mediation, the subscriber or enrollee, or the

1 agent acting on behalf of the subscriber or enrollee, and
2 the plan shall voluntarily agree to mediation. Expenses
3 for mediation shall be borne equally by both sides. The
4 department shall have no administrative or enforcement
5 responsibilities in connection with the voluntary
6 mediation process authorized by this paragraph.

7 (c) The plan's grievance system shall include a system
8 of aging of ~~complaints~~ *grievances* that are pending and
9 unresolved for 30 days or more. On or before January 1,
10 1997, the plan shall provide a quarterly report to the
11 commissioner of ~~complaints~~ *grievances* pending and
12 unresolved for 30 or more days with separate categories
13 of ~~complaints~~ *grievances* for Medicare enrollees and
14 Medi-Cal enrollees. The plan shall include with the report
15 a brief explanation of the reasons each ~~complaint~~
16 *grievance* is pending and unresolved for 30 days or more.
17 The plan may include the following statement in the
18 quarterly report that is made available to the public by
19 the commissioner:

20
21 "Under Medicare and Medi-Cal law, Medicare
22 enrollees and Medi-Cal enrollees each have separate
23 avenues of appeal that are not available to other
24 enrollees. Therefore, ~~complaints~~ *grievance* pending
25 and unresolved may reflect enrollees pursuing their
26 Medicare or Medi-Cal appeal rights."

27
28 If requested by a plan, the commissioner shall include this
29 statement in a written report made available to the public
30 and prepared by the commissioner that describes or
31 compares ~~complaints~~ *grievances* that are pending and
32 unresolved with the plan for 30 days or more.
33 Additionally, the commissioner shall, if requested by a
34 plan, append to that written report a brief explanation,
35 provided in writing by the plan, of the reasons why
36 ~~complaints~~ *grievance* described in that written report are
37 pending and unresolved for 30 days or more. The
38 commissioner shall not be required to include a statement
39 or append a brief explanation to a written report that the

1 commissioner is required to prepare under this chapter,
2 including Sections 1380 and 1397.5.

3 (d) Subject to subparagraph (C) of paragraph (1) of
4 subdivision (b), the grievance, ~~complaint~~, or resolution
5 procedures authorized by this section shall be in addition
6 to any other procedures that may be available to any
7 person, and failure to pursue, exhaust, or engage in the
8 procedures described in this section shall not preclude
9 the use of any other remedy provided by law.

10 (e) Nothing in this section shall be construed to allow
11 the submission to the department of any provider
12 ~~complaint~~ or grievance under this section. However, as
13 part of a provider's duty to advocate for medically
14 appropriate health care for his or her patients pursuant
15 to Sections 510 and 2056 of the Business and Professions
16 Code, nothing in this subdivision shall be construed to
17 prohibit a provider from contacting and informing the
18 department about any concerns he or she has regarding
19 compliance with or enforcement of this chapter.

20 *SEC. 3. Section 1368.01 of the Health and Safety Code*
21 *is amended to read:*

22 1368.01. (a) The grievance system shall require the
23 plan to resolve grievances within 30 days whenever
24 possible and shall require the plan to provide enrollees
25 and subscribers with a written statement on the
26 disposition or pending status of the grievance within 30
27 days of the plan's receipt of the grievance.

28 (b) The grievance system shall include a requirement
29 for expedited plan review of grievances for cases
30 involving an imminent and serious threat to the health of
31 the patient, including, but not limited to, potential loss of
32 life, limb, or major bodily function. When the plan has
33 notice of a case requiring expedited review, the
34 grievance system shall require the plan to immediately
35 inform enrollees and subscribers in writing of their right
36 to notify the department of the grievance. The grievance
37 system shall also require the plan to provide enrollees,
38 subscribers, and the department with a written statement
39 on the disposition or pending status of the grievance no
40 later than ~~five~~ *three* days from receipt of the grievance.

1 *SEC. 4. Section 1368.03 of the Health and Safety Code*
2 *is amended to read:*

3 1368.03. (a) The department may require enrollees
4 and subscribers to participate in a plan's grievance
5 process for up to ~~60~~ 45 days before pursuing a ~~complaint~~
6 *grievance* through the department. However, the
7 department may not impose this waiting period in cases
8 covered by subdivision (b) of Section 1368.01 or in any
9 other case where the department determines that an
10 earlier review is warranted.

11 (b) Notwithstanding subdivision (a), the department
12 may refer any grievance ~~or complaint~~ to the State
13 Department of Health Services, the Department of
14 Aging, the federal Health Care Financing
15 Administration, or any other appropriate governmental
16 entity for investigation and resolution.

17 *SEC. 5. Section 1368.04 of the Health and Safety Code*
18 *is amended to read:*

19 1368.04. (a) The commissioner shall, as appropriate,
20 investigate and take enforcement action against plans
21 regarding ~~complaints~~ *grievances* by enrollees and
22 subscribers, *including grievances that have been*
23 *reviewed pursuant to the independent medical review*
24 *system established pursuant to Article 12 (commencing*
25 *with Section 1399.80).* The commissioner shall
26 periodically evaluate ~~complaints~~ *grievances* to determine
27 if any audit, investigative, or enforcement actions should
28 be undertaken by the department.

29 (b) The commissioner may, after appropriate notice
30 and opportunity for hearing, levy an administrative
31 penalty, by order, in an amount not to exceed two
32 hundred fifty thousand dollars (\$250,000) if the
33 commissioner determines that a health care service plan
34 has knowingly committed, or has performed with ~~such~~
35 *that* frequency as to indicate a general business practice,
36 any of the following:

37 (1) Repeated failure to act promptly and reasonably to
38 investigate and resolve grievances in accordance with
39 Section 1368.01.

(2) Repeated failure to act promptly and reasonably to resolve grievances when the obligation of the plan to the enrollee or subscriber is reasonably clear.

(c) The administrative penalties available to the commissioner pursuant to this section are not exclusive, and may be sought and employed in any combination with civil, criminal, and other administrative remedies deemed warranted by the commissioner to enforce this chapter.

(d) The administrative penalties authorized pursuant to this section shall be paid to the State Corporations Fund.

SEC. 6. Article 12 (commencing with Section 1399.80) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 12. Appeals Seeking Independent Medical Reviews

1399.80. (a) Commencing January 1, 2000, there is established in the department the Independent Medical Review System.

(b) (1) Every health care service plan contract that is issued, amended, renewed, or delivered in this state on or after January 1, 2000, shall provide an enrollee with the opportunity to seek an independent medical review whenever health care services have been denied, significantly delayed, terminated, or otherwise limited by the plan if the plan's decision was based, in whole or in part, on a finding that the proposed health care services are not medically necessary or medically appropriate. For purposes of this section, "enrollee" shall include a designee as defined by paragraph (2) of subdivision (b) of Section 1368, and an enrollee's provider with the consent of the enrollee or the designee.

(2) The independent medical review process authorized by this article is in addition to any other procedures or remedies that may be available. The enrollee's election to either pursue or not pursue, exhaust, or engage in the procedures described in this

1 article does not preclude the use of any other remedy
2 provided by law and shall not be relevant in any
3 subsequent civil or administrative proceeding.

4 (c) No later than January 1, 2000, every health care
5 service plan regulated by the department shall
6 prominently display in every plan contract, on enrollee
7 and subscriber evidence of coverage forms, on the
8 grievance forms required under Section 1368, and on all
9 written notices to enrollees required under the grievance
10 process of the plan, including any written
11 communications to an enrollee that offer the enrollee the
12 opportunity to participate in the grievance process of the
13 plan, and on all written responses to grievances,
14 information concerning the right of an enrollee, as
15 provided in paragraphs (1) and (2) of subdivision (b), to
16 request an independent medical review in cases where
17 the enrollee believes that health care services have been
18 improperly denied, significantly delayed, terminated, or
19 otherwise limited by the plan, or by one of its contracting
20 providers.

21 (d) An enrollee, including a medicare beneficiary
22 enrolled in the health care service plan pursuant to the
23 plan's contract with the federal Health Care Financing
24 Administration, unless that application is expressly
25 preempted by federal law, or a Medi-Cal beneficiary
26 enrolled in a health care service plan under the plan's
27 contract with the State Department of Health Care
28 Services' Medi-Cal program, may apply to the
29 department for an independent medical review when all
30 of the following conditions are met:

31 (1) The enrollee's physician has recommended a
32 treatment as medically necessary or medically
33 appropriate, or the enrollee has received a treatment that
34 the provider determined was medically necessary or
35 medically appropriate for the enrollee's medical
36 condition. For purposes of this article, the enrollee's
37 physician may be an out-of-plan physician. However, the
38 plan shall have no liability for payment of services
39 provided by an out-of-plan physician except, as provided
40 in subdivision (b) of Section 1399.84.

1 (2) *The proposed or rendered treatment has been*
2 *denied, significantly delayed, terminated, or otherwise*
3 *limited by the plan, or by one of its contracting providers,*
4 *based in whole or in part on the basis that the treatment*
5 *is not medically necessary or is not medically appropriate.*

6 (3) *The enrollee has filed a grievance with the plan or*
7 *its contracting provider pursuant to Section 1368, and the*
8 *denial is upheld. However, the enrollee shall not be*
9 *required to participate in the plan's internal grievance*
10 *process for more than 30 days. In the case of a grievance*
11 *that requires expedited review pursuant to Section*
12 *1368.01, the enrollee shall not be required to participate*
13 *in the plan's internal grievance process for more than five*
14 *business days.*

15 (e) *An enrollee may apply to the department for an*
16 *independent medical review of the plan's decision within*
17 *60 days of any of the qualifying periods or events under*
18 *subdivision (d), in a manner determined by the*
19 *commissioner. The commissioner may extend the*
20 *application deadline beyond 60 days if the circumstances*
21 *of a case warrant the extension.*

22 (f) *The enrollee shall pay to the department an*
23 *application processing fee of fifty dollars (\$50), which*
24 *shall be refunded if the enrollee prevails in the review.*
25 *The commissioner may reduce or waive the fee in cases*
26 *of financial hardship. The remaining costs of the review*
27 *shall be borne by the plan as provided in Section 1399.84.*

28 (g) *As part of the application for an independent*
29 *medical review, the enrollee shall provide the*
30 *department with all of the following:*

31 (1) *A brief description of the enrollee's medical*
32 *condition for which health care services were denied,*
33 *significantly delayed, terminated, or otherwise limited.*

34 (2) *A copy of all information provided by the plan or*
35 *any of its contractors concerning its decision regarding*
36 *those health care services.*

37 (3) *Any materials the enrollee submitted to the plan*
38 *in support of the grievance, and any additional material*
39 *that the enrollee believes is relevant.*

1 (4) A written consent to obtain any necessary medical
2 records from the plan, any of its contractors, and any
3 other out-of-network physician the enrollee may have
4 consulted on the matter.

5 (h) Upon notice from the department that the health
6 care service plan's enrollee has applied for an
7 independent medical review, the plan shall provide to
8 the department a copy of all of the following documents
9 within five business days of the plan's receipt of
10 department's notice of a request by an enrollee for an
11 independent review:

12 (A) All medical records relevant to the enrollee's
13 medical condition for which the treatment has been
14 provided or recommended, provided the documents are
15 in the plan's possession. Any medical records provided to
16 the plan after the initial documents are provided to the
17 department shall be forwarded by the plan to the
18 department within five business days. The confidentiality
19 of all medical record information shall be maintained
20 pursuant to applicable state and federal laws.

21 (B) A copy of any relevant documents used by the plan
22 in determining whether the treatment should be
23 provided, and any statement by the plan explaining the
24 reasons for the plan's decision not to provide the
25 treatment on the basis of medical necessity or medical
26 appropriateness. The plan shall provide, upon request, a
27 copy of documents required by this subparagraph, except
28 for any legally privileged information, to the enrollee and
29 the enrollee's physician. The department and the
30 independent review entity shall maintain the
31 confidentiality of any proprietary information of the plan.

32 (C) Any information that was submitted to the plan or
33 to the plan's contracting provider by the enrollee or the
34 enrollee's physician in support of the enrollee's request
35 for the treatment. The confidentiality of any medical
36 record information shall be maintained pursuant to
37 applicable state and federal laws.

38 (i) Each independent medical reviewer shall base his
39 or her determination on whether the proposed or
40 rendered treatment is medically necessary or medically

1 appropriate on scientific and medical evidence regarding
2 the efficacy of the proposed or rendered treatment, or on
3 applicable, generally accepted practice guidelines. A
4 reviewer's determination shall not consider the coverage
5 terms and conditions of the health care service plan
6 contract.

7 1399.81. (a) Upon receipt of an enrollee's request for
8 an independent medical review, the commissioner shall
9 assign the request to an independent medical review
10 organization as described in Section 1399.82 when all of
11 the following conditions are satisfied:

12 (1) The enrollee has provided an executed release to
13 obtain necessary medical records.

14 (2) The enrollee has submitted payment for the
15 application fee, unless the fee is reduced or waived.

16 (3) The commissioner finds that the plan's decision to
17 deny, significantly delay, terminate, or otherwise limit
18 treatment was based, in whole or in part, upon a
19 determination that the proposed health care services are
20 not medically necessary or medically appropriate.

21 (4) The enrollee has followed the plan's grievance
22 process pursuant to subdivision (d) of Section 1399.80.

23 (b) The department shall immediately notify the
24 enrollee in writing as to whether the request for an
25 independent medical review has been approved and, if
26 not approved, the reasons therefor.

27 (c) If the request for review is approved, the
28 department shall immediately provide the independent
29 medical review organization with all necessary
30 information and documents related to the case submitted
31 by the enrollee, the enrollee's physician, and the health
32 care service plan. The organization shall conduct the
33 review in accordance with Section 1399.83 and any
34 regulations or orders of the commissioner adopted
35 pursuant thereto.

36 1399.82. (a) By January 1, 2000, the commissioner
37 shall contract with one or more independent medical
38 review organizations in the state to conduct reviews for
39 purposes of this article. The independent medical review
40 organizations shall be independent of any health care

1 service plans doing business in this state. The
2 commissioner may establish additional requirements,
3 including conflict-of-interest standards, consistent with
4 the purposes of this article, that an organization shall
5 meet in order to qualify for participation in the
6 Independent Medical Review System.

7 (b) (1) The independent medical review
8 organization, any experts it designates to conduct a
9 review, or any officer, director, or employee of the
10 independent entity shall not have any material
11 professional, familial, or financial affiliation, as
12 determined by the commissioner, with any of the
13 following:

14 (A) The plan.

15 (B) Any officer, director, or employee of the plan.

16 (C) A physician, the physician's medical group, or the
17 independent practice association either denying or
18 proposing the health care service in dispute.

19 (D) The institution at which either the proposed
20 health care service, or the alternative service, if any,
21 recommended by the plan, would be provided.

22 (E) The development or manufacture of the principal
23 drug, device, procedure, or other therapy proposed by
24 the enrollee whose treatment is under review, or the
25 alternative therapy, if any, recommended by the plan.

26 (c) The commissioner shall, by July 1, 1999, contract
27 with a private, nonprofit accrediting organization to
28 accredit the independent medical review entities
29 described in subdivision (a). The accrediting
30 organization may grant and revoke accreditation, and
31 shall develop, apply, and enforce accreditation standards
32 that ensure the independence of the independent review
33 entity, the confidentiality of the medical records, and the
34 qualifications and independence of the health care
35 professionals providing the analyses and
36 recommendations requested of them. The accrediting
37 organization shall demonstrate the ability to objectively
38 evaluate the performance of independent medical
39 review organizations and shall demonstrate that it has no
40 conflict of interest, including any material professional,

1 *familial, or financial affiliation, as provided in subdivision*
2 *(b), with any independent medical review organization*
3 *or plan, in accrediting entities for the purpose of*
4 *reviewing medical treatment and treatment*
5 *recommendation decisions made by health care service*
6 *plans.*

7 *(d) In order to receive accreditation for the purposes*
8 *of this section, an independent medical review entity*
9 *shall meet all of the following requirements:*

10 *(1) An independent medical review entity shall not be*
11 *an affiliate or a subsidiary of, nor in any way be owned or*
12 *controlled by, a health plan, or a trade association of*
13 *health plans. A board member, director, officer, or*
14 *employee of the independent medical review entity shall*
15 *not serve as a board member, director, or employee of a*
16 *health care service plan. A board member, director, or*
17 *officer of a health plans or a trade association of health*
18 *plans shall not serve as a board member, director, officer,*
19 *or employee of an independent medical review entity.*

20 *(2) The independent medical review entity shall*
21 *submit to the accrediting organization and to the*
22 *department the following information upon initial*
23 *application for accreditation and, except as otherwise*
24 *provided, annually thereafter upon any change to any of*
25 *the following information:*

26 *(A) The names of all stockholders and owners of more*
27 *than 5 percent of any stock or options, if a publicly held*
28 *organization.*

29 *(B) The names of all holders of bonds or notes in excess*
30 *of one hundred thousand dollars (\$100,000), if any.*

31 *(C) The names of all corporations and organizations*
32 *that the independent medical review entity controls or is*
33 *affiliated with, and the nature and extent of any*
34 *ownership or control, including the affiliated*
35 *organization's type of business.*

36 *(D) The names and biographical sketches of all*
37 *directors, officers, and executives of the independent*
38 *medical review entity, as well as a statement regarding*
39 *any past or present relationships the directors, officers,*
40 *and executives may have with any health care service*

1 *plan, disability insurer, managed care organization,*
2 *provider group, or board or committee of a plan,*
3 *managed care organization, or provider group.*

4 *(E) (i) The percentage of revenue the independent*
5 *medical review entity receives from expert reviews,*
6 *including, but not limited to, external medical reviews,*
7 *quality assurance reviews, and utilization reviews.*

8 *(ii) The names of any health care service plan or*
9 *provider group for which the entity provides review*
10 *services, including, but not limited to, utilization review,*
11 *quality assurance review, and external medical review.*
12 *Any change in this information shall be reported to the*
13 *department within five business days of the change.*

14 *(F) A description of the review process, including, but*
15 *not limited to, the method of selecting expert reviewers*
16 *and matching the expert reviewers to specific cases.*

17 *(G) A description of the system the independent*
18 *medical review entity uses to identify and recruit medical*
19 *professionals to review treatment and treatment*
20 *recommendation decisions, the number of medical*
21 *professionals credentialed, and the types of cases and*
22 *areas of expertise in which the medical professionals are*
23 *credentialed to review.*

24 *(H) A description of how the independent medical*
25 *review entity ensures compliance with the*
26 *conflict-of-interest provisions of this section.*

27 *(3) The independent medical review entity shall*
28 *demonstrate that it has a quality assurance mechanism in*
29 *place that does the following:*

30 *(A) Ensures that the medical professionals retained*
31 *are appropriately credentialed and privileged.*

32 *(B) Ensures that the reviews provided by the medical*
33 *professionals are timely, clear, and credible, and that*
34 *reviews are monitored for quality on an ongoing basis.*

35 *(C) Ensures that the method of selecting medical*
36 *professionals for individual cases achieves a fair and*
37 *impartial panel of medical professionals who are qualified*
38 *to render recommendations regarding the clinical*
39 *conditions and the medical necessity of treatments or*
40 *therapies in question.*

1 (D) Ensures the confidentiality of medical records
2 and the review materials, consistent with the
3 requirements of this section and applicable state and
4 federal law.

5 (E) Ensures the independence of the medical
6 professionals retained to perform the reviews through
7 conflict-of-interest policies and prohibitions, and ensures
8 adequate screening for conflicts-of-interest, pursuant to
9 paragraph (5).

10 (4) Medical professionals selected by independent
11 medical review entities to review medical treatment
12 decisions shall be physicians or other appropriate
13 providers who meet the following minimum
14 requirements:

15 (A) The medical professional shall be a clinician
16 knowledgeable in the treatment of the enrollee's medical
17 condition, knowledgeable about the proposed treatment,
18 and familiar with guidelines and protocols in the area of
19 treatment under review.

20 (B) The medical professional shall hold a
21 nonrestricted license in the State of California, and for
22 physicians, a current certification by a recognized
23 American medical specialty board in the area or areas
24 appropriate to the condition or treatment under review.
25 For good cause shown, such as the unavailability of
26 licensed qualified medical professionals in California or
27 the availability of uniquely qualified clinics outside of
28 California, the medical review entity may utilize a
29 medical professional who holds a nonrestricted license in
30 any state of the United States, provided that the
31 out-of-state medical professional is knowledgeable about
32 the treatment standards in California and applies those
33 standards.

34 (C) The medical professional shall have no history of
35 disciplinary action or sanctions, including, but not limited
36 to, loss of staff privileges or participation restrictions,
37 taken or pending by any hospital, government, or
38 regulatory body.

39 (5) Neither the expert reviewer, nor the independent
40 medical review entity, shall have any material

1 professional, material familial, or material financial
2 affiliation with any of the following:

3 (A) The plan or a provider group of the plan, except
4 that an academic medical center under contract to the
5 plan to provide services to enrollees may qualify as an
6 independent medical review entity provided it will not
7 provide the service and provided the center is not the
8 developer or manufacturer of the proposed treatment.

9 (B) Any officer, director, or management employee of
10 the plan.

11 (C) The physician, the physician's medical group, or
12 the independent practice association (IPA) proposing
13 the treatment.

14 (D) The institution at which the treatment would be
15 provided.

16 (E) The development or manufacture of the
17 treatment proposed for the enrollee whose condition is
18 under review.

19 (F) The enrollee or the enrollee's immediate family.

20 (6) For purposes of this section, the following terms
21 shall have the following meanings:

22 (A) "Material familial affiliation" means any
23 relationship as a spouse, child, parent, sibling, spouse's
24 parent, or child's spouse.

25 (B) "Material professional affiliation" means any
26 physician-patient relationship, any partnership or
27 employment relationship, a shareholder or similar
28 ownership interest in a professional corporation, or any
29 independent contractor arrangement that constitutes a
30 material financial affiliation with any expert or any officer
31 or director of the independent entity. "Material
32 professional affiliation" does not include affiliations that
33 are limited to staff privileges at a health facility.

34 (C) "Material financial affiliation" means any financial
35 interest of more than 5 percent of total annual revenue
36 or total annual income of an entity or individual to which
37 this subdivision applies. "Material financial affiliation"
38 does not include payment by the plan to the independent
39 entity for the services required by this section, nor does
40 "material financial affiliation" include an expert's

1 participation as a contracting plan provider where the
2 expert is affiliated with an academic medical center or a
3 National Cancer Institute-designated clinical cancer
4 research center.

5 (e) The independent review process established by
6 this section shall be required on and after January 1, 2000.

7 (f) The accrediting organization shall provide, upon
8 the request of any interested person, a copy of all
9 nonproprietary information, as determined by the
10 commissioner, filed with it by an independent medical
11 review organization seeking accreditation under this
12 article. The accrediting organization may charge a
13 nominal fee to the interested person for photocopying the
14 requested information.

15 1399.83. (a) Upon receipt from the department of
16 information and documents related to a case pursuant to
17 subdivision (c) of Section 1399.81, the medical
18 professional or professionals selected to conduct the
19 review by the independent medical review organization
20 shall promptly review all pertinent medical records of the
21 enrollee, consulting physician reports, as well as any other
22 information submitted to the organization by the
23 department or by any of the parties to the dispute.
24 Following its review, the reviewer or reviewers shall
25 determine whether the proposed treatment was
26 medically necessary or medically appropriate based on
27 scientific and medical evidence regarding the efficacy of
28 the proposed or rendered treatment, or on applicable,
29 generally accepted practice guidelines.

30 (b) The organization shall complete its review and
31 make its determination in writing, and in layperson's
32 terms to the maximum extent practicable, within 30 days
33 of the receipt of the application for review from the
34 department, or within less time as prescribed by the
35 commissioner. If a treatment has not been provided and
36 the enrollee's physician determines that the treatment
37 would be significantly less effective if not promptly
38 initiated, the analyses and determinations of the medical
39 professionals shall be rendered within four days of the
40 request for the expedited review. At the request of the

1 medical professionals reviewing the decision to deny
2 treatment on the basis of medical necessity, the deadline
3 shall be extended by up to three days for any delay in
4 receiving the application and supporting and opposing
5 documents and papers.

6 (c) The medical professionals' analyses and
7 determinations shall state whether the treatment is
8 medically necessary or medically appropriate. Medical
9 professionals shall cite the enrollee's medical condition,
10 the relevant documents, and the relevant medical and
11 scientific evidence to support the determination.

12 (d) The independent medical review entity shall
13 provide the commissioner, the plan, the enrollee, and the
14 enrollee's physician with the analyses and determinations
15 of the medical professionals reviewing the decision, a
16 description of the qualifications of the medical
17 professionals, and the names of the reviewers. The
18 commissioner shall adopt the determination of the
19 independent medical review organization.

20 (e) The determination of the medical professionals
21 reviewing the plan's decision to deny treatment on the
22 basis of medical necessity shall be binding on the plan. If
23 more than one medical professional reviews the decision,
24 the recommendation of the majority shall prevail. If the
25 medical professionals reviewing the decision to deny
26 treatment are evenly split as to whether treatment should
27 be provided, the decision shall be in favor of providing the
28 treatment.

29 (f) (1) Subject to the provisions of the Evidence
30 Code, the opinion of the medical professional reviewer on
31 whether the rendered or proposed treatment was
32 medically necessary or medically appropriate may be
33 offered for admissibility solely on that issue by a party to
34 the medical review who calls the medical professional as
35 his or her expert witness in any subsequent
36 administrative or civil proceeding. Any opinion evidence
37 of the medical professional reviewer that is admitted shall
38 be considered only as the testimony of the party's expert
39 witness, and not as the testimony of the medical
40 professional conducting the medical review. Any opinion

1 evidence of the medical professional reviewer that is
2 admitted shall be accorded the same weight as other
3 expert opinion evidence and shall be subject to the same
4 rules, including cross-examination.

5 (2) Any opinion of medical necessity or medical
6 appropriateness based in whole or in part on whether the
7 proposed or rendered treatment is a covered treatment
8 under the terms and conditions of the health care service
9 plan shall be inadmissible.

10 (g) After removing the names of the parties,
11 including, but not limited to, the enrollee, all medical
12 providers, the plan and any of its employees or
13 contractors, commissioner decisions adopting a
14 determination of an independent medical review
15 organization shall be made available by the department
16 to the public upon request, at the department's cost.

17 1399.84. (a) Upon receiving the independent
18 medical review entity's decision issued pursuant to
19 Section 1399.83 that a proposed or rendered medical
20 treatment was medically necessary or medically
21 appropriate, the plan shall promptly implement the
22 decision.

23 (b) In any case where an enrollee secured health care
24 services outside of the plan network, which services are
25 later found by the independent medical review
26 organization to have been medically necessary or
27 medically appropriate, the commissioner shall require
28 the plan to reimburse the enrollee for any reasonable
29 costs associated with those services when the
30 commissioner finds that the enrollee's decision to secure
31 the services outside of the plan network was reasonable
32 under the circumstances and the treatment or therapies
33 were a covered benefit under the plan's terms and
34 conditions of coverage.

35 (c) In addition to requiring plan compliance
36 regarding subdivisions (a) and (b), the commissioner
37 shall review individual cases submitted for independent
38 medical review to determine whether any enforcement
39 actions, including penalties, may be appropriate. In
40 particular, where harm to an enrollee has already

1 occurred because of the decision of a plan to deny,
2 significantly delay, terminate, or otherwise limit covered
3 health care services that an independent medical review
4 determines to be medically necessary or medically
5 appropriate, the commissioner shall impose penalties.

6 (d) Pursuant to Section 1368.04, the commissioner
7 shall periodically evaluate independent medical review
8 cases to determine if any audit, investigative, or
9 enforcement actions should be undertaken by the
10 department, particularly if a plan repeatedly fails to act
11 promptly and reasonably to resolve grievances associated
12 with a denial, significant delay, termination, or other
13 limits on medically necessary or medically appropriate
14 health care services when the obligation of the plan to
15 provide those health care services to enrollees or
16 subscribers is reasonably clear.

17 (e) The commissioner shall establish a reasonable,
18 per-case reimbursement schedule to pay the costs of
19 independent medical review organization reviews,
20 which may vary depending on the type of medical
21 condition under review and on other relevant factors.

22 (f) Aside from the application fee of fifty dollars (\$50),
23 the costs of an independent medical review shall be borne
24 by the plan pursuant to a schedule of fees established by
25 the commissioner.

26 SEC. 7. Article 2.55 (commencing with Section
27 10145.80) is added to Chapter 1 of Part 2 of Division 2 of
28 the Insurance Code, to read:

29
30 Article 2.55. Appeals Seeking Independent Review

31
32 10145.80. (a) Commencing January 1, 2000, there is
33 established in the department the Independent Review
34 System.

35 (b) (1) Every disability insurance contract that is
36 issued, amended, renewed, or delivered in this state on or
37 after January 1, 2000, shall provide an insured with the
38 opportunity to seek an independent review whenever
39 services have been denied, significantly delayed,
40 terminated, or otherwise limited by the insurer if the

1 insurer's decision was based, in whole or in part, on a
2 finding that the proposed services are not medically
3 necessary or medically appropriate. For purposes of this
4 section, "insured" shall include a designee and an
5 insured's provider with the consent of the insured or the
6 designee.

7 (2) The independent review process authorized by
8 this article is in addition to any other procedures or
9 remedies that may be available. The insured's election to
10 either pursue or not pursue, exhaust, or engage in the
11 procedures described in this article does not preclude the
12 use of any other remedy provided by law and shall not be
13 relevant in any subsequent civil or administrative
14 proceeding.

15 (c) No later than January 1, 2000, every disability
16 insurer regulated by the department shall prominently
17 display in every insurer contract, on insured and
18 subscriber evidence of coverage forms, on the grievance
19 forms, and on all written notices to insureds required
20 under the grievance process of the insurer, including any
21 written communications to an insured that offer the
22 insured the opportunity to participate in the grievance
23 process of the insurer, and on all written responses to
24 grievances, information concerning the right of an
25 insured, as provided in paragraphs (1) and (2) of
26 subdivision (b), to request an independent review in
27 cases where the insured believes that services have been
28 improperly denied, significantly delayed, terminated, or
29 otherwise limited by the insurer, or by one of its
30 contracting providers.

31 (d) An insured may apply to the department for an
32 independent review when all of the following conditions
33 are met:

34 (1) The insured's physician has recommended a
35 treatment as medically necessary or medically
36 appropriate, or the insured has received a treatment that
37 the provider determined was medically necessary or
38 medically appropriate for the insured's medical
39 condition. For purposes of this article, the insured's
40 physician may be an out-of-insurer physician. However,

1 *the insurer shall have no liability for payment of services*
2 *provided by an out-of-insurer physician except as*
3 *provided in subdivision (b) of Section 10145.84.*

4 *(2) The proposed or rendered treatment has been*
5 *denied, significantly delayed, terminated, or otherwise*
6 *limited by the insurer, or by one of its contracting*
7 *providers based, in whole or in part, on the basis that the*
8 *treatment is not medically necessary or medically*
9 *appropriate.*

10 *(3) The insured has filed a grievance with the insurer*
11 *or its contracting provider, and the denial was upheld.*
12 *However, the insured shall not be required to participate*
13 *in the insurer's internal grievance process for more than*
14 *30 days. In the case of a grievance that requires expedited*
15 *review, the insured shall not be required to participate in*
16 *the insurer's internal grievance process for more than*
17 *five business days.*

18 *(e) An insured may apply to the department for an*
19 *independent review of the insurer's decision within 60*
20 *days of any of the qualifying periods or events under*
21 *subdivision (d), in a manner determined by the*
22 *commissioner. The commissioner may extend the*
23 *application deadline beyond 60 days if the circumstances*
24 *of a case warrant the extension.*

25 *(f) The insured shall pay to the department an*
26 *application processing fee of fifty dollars (\$50), which*
27 *shall be refunded if the insured prevails in the review.*
28 *The commissioner may reduce or waive the fee in cases*
29 *of financial hardship. The remaining costs of the review*
30 *shall be borne by the insurer as provided in Section*
31 *10145.84.*

32 *(g) As part of the application for an independent*
33 *review, the insured shall provide the department with all*
34 *of the following:*

35 *(1) A brief description of the insured's medical*
36 *condition for which services were denied, significantly*
37 *delayed, terminated, or otherwise limited.*

38 *(2) A copy of all information provided by the insurer*
39 *or any of its contractors concerning its decision regarding*
40 *those services.*

1 (3) Any materials the insured submitted to the insurer
2 in support of the grievance, and any additional material
3 that the insured believes is relevant.

4 (4) A written consent to obtain any necessary medical
5 records from the insurer, any of its contractors, and any
6 other out-of-network physician the insured may have
7 consulted on the matter.

8 (h) Upon notice from the department that the
9 disability insurer's insured has applied for an
10 independent review, the insurer shall provide to the
11 department a copy of all of the following documents
12 within five business days of the insurer's receipt of
13 department's notice of a request by an insured for an
14 independent review:

15 (A) All medical records relevant to the insured's
16 medical condition for which the treatment has been
17 provided or recommended, provided the documents are
18 in the insurer's possession. Any medical records provided
19 to the insurer after the initial documents are provided to
20 the department shall be forwarded by the insurer to the
21 department within five business days. The confidentiality
22 of all medical record information shall be maintained
23 pursuant to applicable state and federal laws.

24 (B) A copy of any relevant documents used by the
25 insurer in determining whether the treatment should be
26 provided, and any statement by the insurer explaining
27 the reasons for the insurer's decision not to provide the
28 treatment on the basis of medical necessity or medical
29 appropriateness. The insurer shall provide, upon request,
30 a copy of documents required by this subparagraph,
31 except for any legally privileged information, to the
32 insured and the insured's physician. The department and
33 the independent review entity shall maintain the
34 confidentiality of any proprietary information of the
35 insurer.

36 (C) Any information that was submitted to the insurer
37 or to the insurer's contracting provider by the insured or
38 the insured's physician in support of the insured's request
39 for the treatment. The confidentiality of any medical

1 record information shall be maintained pursuant to
2 applicable state and federal laws.

3 (i) Each independent reviewer shall base his or her
4 determination on whether the proposed or rendered
5 treatment is medically necessary or medically
6 appropriate on scientific and medical evidence regarding
7 the efficacy of the proposed or rendered treatment, or on
8 applicable, generally accepted practice guidelines. A
9 reviewer's determination shall not consider the coverage
10 terms and conditions of the disability insurance contract.

11 10145.81. (a) Upon receipt of an insured's request for
12 an independent review, the commissioner shall assign the
13 request to an independent review organization as
14 described in Section 10145.82 when all of the following
15 conditions are satisfied:

16 (1) The insured has provided an executed release to
17 obtain necessary medical records.

18 (2) The insured has submitted payment for the
19 application fee, unless the fee is reduced or waived.

20 (3) The commissioner finds that the insurer's decision
21 to deny, significantly delay, terminate, or otherwise limit
22 treatment was based, in whole or in part, upon a
23 determination that the proposed services are not
24 medically necessary or medically appropriate.

25 (4) The insured has followed the insurer's grievance
26 process pursuant to subdivision (d) of Section 10145.80.

27 (b) The department shall immediately notify the
28 insured in writing as to whether the request for an
29 independent review has been approved and, if not
30 approved, the reasons therefor.

31 (c) If the request for review is approved, the
32 department shall immediately provide the independent
33 review organization with all necessary information and
34 documents related to the case submitted by the insured,
35 the insured's physician, and the disability insurer. The
36 organization shall conduct the review in accordance with
37 Section 10145.83 and any regulations or orders of the
38 commissioner adopted pursuant thereto.

39 10145.82. (a) By January 1, 2000, the commissioner
40 shall contract with one or more independent review

1 organizations in the state to conduct reviews for purposes
2 of this article. The independent review organizations
3 shall be independent of any disability insurer doing
4 business in this state. The commissioner may establish
5 additional requirements, including conflict-of-interest
6 standards, consistent with the purposes of this article, that
7 an organization shall meet in order to qualify for
8 participation in the Independent Review System.

9 (b) (1) The independent review organization, any
10 experts it designates to conduct a review, or any officer,
11 director, or employee of the independent entity shall not
12 have any material professional, familial, or financial
13 affiliation, as determined by the commissioner, with any
14 of the following:

15 (A) The insurer.

16 (B) Any officer, director, or employee of the insurer.

17 (C) A physician, the physician's medical group, or the
18 independent practice association either denying or
19 proposing the health care service in dispute.

20 (D) The institution at which either the proposed
21 health care service, or the alternative service, if any,
22 recommended by the insurer, would be provided.

23 (E) The development or manufacture of the principal
24 drug, device, procedure, or other therapy proposed by
25 the insured whose treatment is under review, or the
26 alternative therapy, if any, recommended by the insurer.

27 (c) The commissioner shall, by July 1, 1999, contract
28 with a private, nonprofit accrediting organization to
29 accredit the independent review entities described in
30 subdivision (a). The accrediting organization may grant
31 and revoke accreditation, and shall develop, apply, and
32 enforce accreditation standards that ensure the
33 independence of the independent review entity, the
34 confidentiality of the medical records, and the
35 qualifications and independence of the health care
36 professionals providing the analyses and
37 recommendations requested of them. The accrediting
38 organization shall demonstrate the ability to objectively
39 evaluate the performance of independent review
40 organizations and shall demonstrate that it has no conflict

1 of interest, including any material professional, familial,
2 or financial affiliation, as provided in subdivision (b), with
3 any independent review organization or insurer, in
4 accrediting entities for the purpose of reviewing medical
5 treatment and treatment recommendation decisions
6 made by disability insurers.

7 (d) In order to receive accreditation for the purposes
8 of this section, an independent review entity shall meet
9 all of the following requirements:

10 (1) An independent review entity shall not be an
11 affiliate or a subsidiary of, nor in any way be owned or
12 controlled by, a health or disability insurer, or a trade
13 association of health or disability insurers. A board
14 member, director, officer, or employee of the
15 independent review entity shall not serve as a board
16 member, director or employee of a disability insurer. A
17 board member, director, or officer of a disability or health
18 insurer or a trade association of disability or health
19 insurers shall not serve as a board member, director,
20 officer, or employee of an independent review entity.

21 (2) The independent review entity shall submit to the
22 accrediting organization and to the department the
23 following information upon initial application for
24 accreditation and, except as otherwise provided, annually
25 thereafter upon any change to any of the following
26 information:

27 (A) The names of all stockholders and owners of more
28 than 5 percent of any stock or options, if a publicly held
29 organization.

30 (B) The names of all holders of bonds or notes in excess
31 of one hundred thousand dollars (\$100,000), if any.

32 (C) The names of all corporations and organizations
33 that the independent review entity controls or is
34 affiliated with, and the nature and extent of any
35 ownership or control, including the affiliated
36 organization's type of business.

37 (D) The names and biographical sketches of all
38 directors, officers, and executives of the independent
39 review entity, as well as a statement regarding any past
40 or present relationships the directors, officers, and

1 executives may have with any disability health insurer;
2 disability insurer, managed care organization, provider
3 group, or board or committee of an insurer, managed care
4 organization, or provider group.

5 (E) (i) The percentage of revenue the independent
6 review entity receives from expert reviews, including,
7 but not limited to, external medical reviews, quality
8 assurance reviews, and utilization reviews.

9 (ii) The names of any disability insurer or provider
10 group for which the entity provides review services,
11 including, but not limited to, utilization review, quality
12 assurance review, and external medical review. Any
13 change in this information shall be reported to the
14 department within five business days of the change.

15 (F) A description of the review process, including, but
16 not limited to, the method of selecting expert reviewers
17 and matching the expert reviewers to specific cases.

18 (G) A description of the system the independent
19 review entity uses to identify and recruit medical
20 professionals to review treatment and treatment
21 recommendation decisions, the number of medical
22 professionals credentialed, and the types of cases and
23 areas of expertise in which the medical professionals are
24 credentialed to review.

25 (H) A description of how the independent review
26 entity ensures compliance with the conflict-of-interest
27 provisions of this section.

28 (3) The independent review entity shall demonstrate
29 that it has a quality assurance mechanism in place that
30 does the following:

31 (A) Ensures that the medical professionals retained
32 are appropriately credentialed and privileged.

33 (B) Ensures that the reviews provided by the medical
34 professionals are timely, clear, and credible, and that
35 reviews are monitored for quality on an ongoing basis.

36 (C) Ensures that the method of selecting medical
37 professionals for individual cases achieves a fair and
38 impartial panel of medical professionals who are qualified
39 to render recommendations regarding the clinical

1 conditions and the medical necessity of treatments or
2 therapies in question.

3 (D) Ensures the confidentiality of medical records
4 and the review materials, consistent with the
5 requirements of this section and applicable state and
6 federal law.

7 (E) Ensures the independence of the medical
8 professionals retained to perform the reviews through
9 conflict-of-interest policies and prohibitions, and ensures
10 adequate screening for conflicts of interest, pursuant to
11 paragraph (5).

12 (4) Medical professionals selected by independent
13 review entities to review medical treatment decisions
14 shall be physicians or other appropriate providers who
15 meet the following minimum requirements:

16 (A) The medical professional shall be a clinician
17 knowledgeable in the treatment of the insured's medical
18 condition, knowledgeable about the proposed treatment,
19 and familiar with guidelines and protocols in the area of
20 treatment under review.

21 (B) The medical professional shall hold a
22 nonrestricted license in the State of California, and for
23 physicians, a current certification by a recognized
24 American medical specialty board in the area or areas
25 appropriate to the condition or treatment under review.
26 For good cause shown, such as the unavailability of
27 licensed qualified medical professionals in California or
28 the availability of uniquely qualified clinics outside of
29 California, the medical review entity may utilize a
30 medical professional who holds a nonrestricted license in
31 any state of the United States, provided that the
32 out-of-state medical professional is knowledgeable about
33 the treatment standards in California and applies those
34 standards.

35 (C) The medical professional shall have no history of
36 disciplinary action or sanctions, including, but not limited
37 to, loss of staff privileges or participation restrictions,
38 taken or pending by any hospital, government, or
39 regulatory body.

1 (5) Neither the expert reviewer, nor the independent
2 review entity, shall have any material professional,
3 material familial, or material financial affiliation with any
4 of the following:

5 (A) The insurer or a provider group of the insurer,
6 except that an academic medical center under contract
7 to the insurer to provide services to insureds may qualify
8 as an independent review entity provided it will not
9 provide the service and provided the center is not the
10 developer or manufacturer of the proposed treatment.

11 (B) Any officer, director, or management employee of
12 the insurer.

13 (C) The physician, the physician's medical group, or
14 the independent practice association (IPA) proposing
15 the treatment.

16 (D) The institution at which the treatment would be
17 provided.

18 (E) The development or manufacture of the
19 treatment proposed for the insured whose condition is
20 under review.

21 (F) The insured or the insured's immediate family.

22 (6) For purposes of this section, the following terms
23 shall have the following meanings:

24 (A) "Material familial affiliation" means any
25 relationship as a spouse, child, parent, sibling, spouse's
26 parent, or child's spouse.

27 (B) "Material professional affiliation" means any
28 physician-patient relationship, any partnership or
29 employment relationship, a shareholder or similar
30 ownership interest in a professional corporation, or any
31 independent contractor arrangement that constitutes a
32 material financial affiliation with any expert or any officer
33 or director of the independent entity. "Material
34 professional affiliation" does not include affiliations that
35 are limited to staff privileges at a health facility.

36 (C) "Material financial affiliation" means any financial
37 interest of more than 5 percent of total annual revenue
38 or total annual income of an entity or individual to which
39 this subdivision applies. "Material financial affiliation"
40 does not include payment by the insurer to the

1 independent entity for the services required by this
2 section, nor does “material financial affiliation” include
3 an expert’s participation as a contracting insurer provider
4 where the expert is affiliated with an academic medical
5 center or a National Cancer Institute-designated clinical
6 cancer research center.

7 (e) The independent review process established by
8 this section shall be required on and after January 1, 2000.

9 (f) The accrediting organization shall provide, upon
10 the request of any interested person, a copy of all
11 nonproprietary information, as determined by the
12 commissioner, filed with it by an independent review
13 organization seeking accreditation under this article. The
14 accrediting organization may charge a nominal fee to the
15 interested person for photocopying the requested
16 information.

17 10145.83. (a) Upon receipt from the department of
18 information and documents related to a case pursuant to
19 subdivision (c) of Section 10145.81, the medical
20 professional or professionals selected to conduct the
21 review by the independent review organization shall
22 promptly review all pertinent medical records of the
23 insured, consulting physician reports, as well as any other
24 information submitted to the organization by the
25 department or by any of the parties to the dispute.
26 Following its review, the reviewer or reviewers shall
27 determine whether the proposed treatment was
28 medically necessary or medically appropriate based on
29 scientific and medical evidence regarding the efficacy of
30 the proposed or rendered treatment, or on applicable,
31 generally accepted practice guidelines.

32 (b) The organization shall complete its review and
33 make its determination in writing, and in layperson’s
34 terms to the maximum extent practicable, within 30 days
35 of the receipt of the application for review from the
36 department, or within less time as prescribed by the
37 commissioner. If a treatment has not been provided and
38 the insured’s physician determines that the treatment
39 would be significantly less effective if not promptly
40 initiated, the analyses and determinations of the medical

1 professionals shall be rendered within four days of the
2 request for the expedited review. At the request of the
3 medical professionals reviewing the decision to deny
4 treatment on the basis of medical necessity, the deadline
5 shall be extended by up to three days for any delay in
6 receiving the application and supporting and opposing
7 documents and papers.

8 (c) The medical professionals' analyses and
9 determinations shall state whether the treatment is
10 medically necessary or medically appropriate. Medical
11 professionals shall cite the insured's medical condition,
12 the relevant documents, and the relevant medical and
13 scientific evidence to support the determination.

14 (d) The independent review entity shall provide the
15 commissioner, the insurer, the insured, and the insured's
16 physician with the analyses and determinations of the
17 medical professionals reviewing the decision, a
18 description of the qualifications of the medical
19 professionals, and the names of the reviewers. The
20 commissioner shall adopt the determination of the
21 independent review organization.

22 (e) The determination of the medical professionals
23 reviewing the insurer's decision to deny treatment on the
24 basis of medical necessity shall be binding on the insurer.
25 If more than one medical professional reviews the
26 decision, the recommendation of the majority shall
27 prevail. If the medical professionals reviewing the
28 decision to deny treatment are evenly split as to whether
29 treatment should be provided, the decision shall be in
30 favor of providing the treatment.

31 (f) (1) Subject to the provisions of the Evidence
32 Code, the opinion of the medical professional reviewer on
33 whether the rendered or proposed treatment was
34 medically necessary or medically appropriate may be
35 offered for admissibility solely on that issue by a party to
36 the medical review who calls the medical professional as
37 his or her expert witness in any subsequent
38 administrative or civil proceeding. Any opinion evidence
39 of the medical professional reviewer that is admitted shall
40 be considered only as the testimony of the party's expert

1 witness, and not as the testimony of the medical
2 professional conducting the medical review. Any opinion
3 evidence of the medical professional reviewer that is
4 admitted shall be accorded the same weight as other
5 expert opinion evidence and shall be subject to the same
6 rules, including cross-examination.

7 (2) Any opinion of medical necessity or medical
8 appropriateness based in whole or in part on whether the
9 proposed or rendered treatment is a covered treatment
10 under the terms and conditions of the disability insurance
11 contract shall be inadmissible.

12 (g) After removing the names of the parties,
13 including, but not limited to, the insured, all medical
14 providers, the insurer, and any of its employees or
15 contractors, commissioner decisions adopting a
16 determination of an independent review organization
17 shall be made available by the department to the public
18 upon request, at the department's cost.

19 10145.84. (a) Upon receiving the independent
20 review entity's decision issued pursuant to Section
21 10145.83 that a proposed or rendered medical treatment
22 was medically necessary or medically appropriate, the
23 insurer shall promptly implement the decision.

24 (b) In any case where an insured secured services
25 outside of the insurer network, which services are later
26 found by the independent review organization to have
27 been medically necessary or medically appropriate, the
28 commissioner shall require the insurer to reimburse the
29 insured for any reasonable costs associated with those
30 services when the commissioner finds that the insured's
31 decision to secure the services outside of the insurer
32 network was reasonable under the circumstances and the
33 treatment or therapies were a covered benefit under the
34 insurer's terms and conditions of coverage.

35 (c) In addition to requiring insurer compliance
36 regarding subdivisions (a) and (b), the commissioner
37 shall review individual cases submitted for independent
38 review to determine whether any enforcement actions,
39 including penalties, may be appropriate. In particular,
40 where harm to an insured has already occurred because

1 of the decision of a insurer to deny, significantly delay,
2 terminate, or otherwise limit covered services that an
3 independent review determines to be medically
4 necessary or medically appropriate, the commissioner
5 shall impose penalties.

6 (d) The commissioner shall periodically evaluate
7 independent review cases to determine if any audit,
8 investigative, or enforcement actions should be
9 undertaken by the department, particularly if a insurer
10 repeatedly fails to act promptly and reasonably to resolve
11 grievances associated with a denial, significant delay,
12 termination, or other limits on medically necessary or
13 medically appropriate services when the obligation of the
14 insurer to provide those services to insureds or
15 subscribers is reasonably clear.

16 (e) The commissioner shall establish a reasonable,
17 per-case reimbursement schedule to pay the costs of
18 independent review organization reviews, which may
19 vary depending on the type of medical condition under
20 review and on other relevant factors.

21 (f) Aside from the application fee of fifty dollars (\$50),
22 the costs of an independent review shall be borne by the
23 insurer pursuant to a schedule of fees established by the
24 commissioner.

25 SEC. 8. No reimbursement is required by this act
26 pursuant to Section 6 of Article XIII B of the California
27 Constitution because the only costs that may be incurred
28 by a local agency or school district will be incurred
29 because this act creates a new crime or infraction,
30 eliminates a crime or infraction, or changes the penalty
31 for a crime or infraction, within the meaning of Section
32 17556 of the Government Code, or changes the definition
33 of a crime within the meaning of Section 6 of Article
34 XIII B of the California Constitution.

35 Notwithstanding Section 17580 of the Government
36 Code, unless otherwise specified, the provisions of this act
37 shall become operative on the same date that the act
38 takes effect pursuant to the California Constitution.

1 *SEC. 9. This act shall not become operative unless*
2 *Senate Bill 1504 and Senate Bill 1653 of the 1997-1998*
3 *Regular Session are also enacted and become operative.*

4
5
6 **All matter omitted in this version of the**
7 **bill appears in the bill as amended in the**
8 **Assembly, May 22, 1998 (JR 11)**
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